FREQUENTLY ASKED QUESTIONS

MEDICARE ISSUES

General Medicare Billing & Payment Policy:

Medicare may pay for covered services if the beneficiary is a Medicare beneficiary and no other Federal or State agency is responsible for payment.

Use of Alternate Care Units

Q.1. Can a bed in a psychiatric unit be used for acute care patients admitted during a disaster?

A. Yes, beds in a psychiatric unit can be used for acute care; however, it should be fully documented in hospital records. In addition, the acute portion of the hospital should bill for all Medicare-covered services; the psychiatric unit should record the services/charges as non-Medicare. (9/1/2005)

Payment Methods

Q.2. Will a hospital be eligible for additional payment for rendering services to patients that remain in the hospital due to the fact that they continue to need medical care less than acute level?

A. Medicare will pay the DRG rate and any cost outliers for the entire stay until the Medicare patient can be moved to an appropriate facility. (9/1/2005)

Q.3. Are prospective payment providers going to be paid using a special payment method? If not, is there a special DRG that IPPS providers will be reimbursed for this situation?

A. Normal prospective payment procedures apply to those hospitals reimbursed under the inpatient prospective payment system. (9/1/2005)

Evacuation/Transfers

Q.4. How should the following situation be handled relative to Medicare billing? Hospital "A" is evacuated and patients are sent to hospital "B". These same patients are later moved to a shelter because hospital "B" is now forced to evacuate.

A. Hospital "A" would discharge the patient and reflect a transfer to hospital "B" indicating the appropriate patient status (from locator 21 of the UB-82):

02 - if transferred to another acute care facility (PPS);
03 - if transferred to a SNF;
04 - if transferred to a nursing home not considered a skilled facility;
62 - if transferred to an Inpatient Rehab Facility (IRF);
63 - if transferred to a Long Term Care Hospital (LTCH);
65 - if transferred to a Psychiatric Facility;
66 - if transferred to a Critical Access Hospital; or
05 - if transferred to any other type of medical facility.

Assuming that hospital "B" will be receiving the patient back due to their medical condition still warranting acute medical care, hospital "B" would reflect the admission date from hospital "A" as the actual date of patient receipt and would reflect the days absent in a non-medical facility as furlough/leave of absence days and continue their care upon return of the patient. (9/1/2005)

Q.5. If a patient was transferred from hospital "A" to hospital "B" and the patient is planning to return to hospital "A", how are the two facilities to bill their claims and receive Payment?

A. When the transfer is of short duration, the first facility will continue to bill as if the patient had not been transferred. The initial facility is responsible for Payment to the receiving facility for the days they housed the beneficiary. CMS is defining “short duration” as 30 days or less. However, if the initial facility is damaged and unable to accept the patient, the initial facility must transfer care to the receiving facility. The transfer must occur as soon as the receiving facility is notified that the initial facility is unable to receive the patient. (9/1/2005)

Q.6. In some instances, hospital "A" transferred a patient to hospital "B" but because of the disaster hospital "B" had to transfer the patient again and 'hospital "A" is no longer aware of the location of their patient. What does a hospital do that cannot locate their patient?

A. If the receiving hospital/health care facility transferred your patient to some other facility or even discharged the patient, the first hospital should bill Medicare indicating a discharge/transfer (using the appropriate patient status code as indicated previously). The second health care facility would reflect the patient admitted on the day of the transfer from the first facility and discharge the patient upon transfer to another facility or discharge to other location. (9/1/2005)

Q.7. What is CMS’ policy relating to ambulance payments for evacuations?

A. Medicare policy provides contractors with discretion to determine Medicare payment for services provided under unusual circumstances. While CMS recognizes it is in the patients' best interest to be evacuated as soon as possible during an emergency, contractors have the responsibility to determine if Medicare payment should be made for the evacuation.

In most cases, mass emergency evacuations billed to Part B are for nursing home patients from ambulance suppliers. Nursing homes are required to have an emergency evacuation plan as a condition of participation. Many will have insurance to cover these situations. If the facility has insurance that will cover the evacuations, Medicare is the secondary payer. If not, contractors should consider the following points prior to making payment:

- Medicare's medical necessity requirements apply in all cases;
- Payment may be made only if the patient was transported to an approved destination; and,
- Multiple patient transport payment provisions apply in all cases.

Due to the unusual nature of the services provided during the hurricane, contractors should evaluate circumstances relating to the affected beneficiaries and make coverage decisions based on the facts for individual situations. Contractors may have to vary coverage determinations based on a patient's individual situation. (9/1/2005)

Q.8. Do the modifications and flexibilities described in these Q&As in response to Hurricane Katrina apply only to providers in the states in which the Secretary of Health and Human Services has declared a public health emergency?

A. The waivers apply only to providers in the states in which the Secretary has declared a public health emergency, and only to the extent that the provider in question has been affected by the hurricane or is treating evacuees. Those states are: Louisiana, Mississippi, Alabama, Florida, Texas, Arkansas, Colorado, Georgia, North Carolina, Oklahoma, Tennessee, West Virginia, and Utah. The waivers for all states were effective on August 29, 2005. The waivers do not apply to care provided to an evacuee by a provider not located in one of the designated states. (9/8/05)

Post-Evacuation and Payment

Q.9. Due to the unexpected emergent nature of the PPS hospital evacuation, there was not time to work out a financial arrangement with the receiving health care institution. Are PPS hospitals responsible to reimburse the receiving hospital for full charges or how can assistance be provided if problems arise with post evacuation Payment negotiations?

A. Financial agreements between providers are a private matter between those two parties. CMS cannot dictate the terms of these agreements or interfere in providers' negotiations. If the facilities are unable to work out a financial arrangement, CMS may consider allowing each facility to bill for the services it provided. CMS will make these considerations on a case-by-case basis. (9/1/2005)

Billing and Payment: Non-Medicare Facilities

Q.10. Due to evacuation of a PPS hospital, the Medicare patients were transferred to a non-Medicare medical facility. How is the claim to be billed?

A. The PPS hospital should bill Medicare for all days and charges associated with the patient's care as if the patient was never evacuated from the PPS facility. The PPS facility should make arrangements to reimburse the non-Medicare facility for services /charges associated with the period of time the Medicare patient was in their facility. (9/1/2005)

Billing and Payment: Transfers and Utilization of Chemotherapy Equipment

Q.11. Patients are taken to a second facility for chemotherapy services because the equipment at the original facility is not operating. How should this be billed?

A. The originating medical facility must bill for these services as part of the original inpatient stay and reimburse the second facility for the use of their chemotherapy services. It is important that this occur so that claims are not submitted with overlapping dates of service. If the services were rendered in an outpatient setting at both facilities, both facilities may bill for their own services as long as the dates of services do not overlap. (9/1/2005)

Billing and Payment: Patient and Equipment Transfers

Q.12. In some cases, a hospital is not only transferring the patient, but is also transferring personnel and equipment. How are the costs handled in this situation?

A. These hospital costs would be reimbursed as an element of the DRG which is paid under PPS. If the provider is paid on a cost basis, these personnel and equipment costs would be allowable costs. (9/1/2005)

Billing and Payment: Long Term Care Hospitals (LTCH)

Q.13. Will acute care patients admitted to a LTCH from an acute care hospital as a result of the evacuation of that acute care hospital be counted in the determination of the LTCH's average length of stay?

A: No, acute care patients admitted to a LTCH as a result of the evacuation from the acute care hospital will be treated separately and will not be included in the calculation of the LTCH's average length of stay. The LTCH should document that the admission was related to evacuation of an acute care hospital, and which acute care hospital the patient was evacuated from. (9/6/2005)

Billing and Payment: Enrollment Status (HIC number)

Q.14. If an acute care hospital receives patients from a nursing home with no records or Medicare health insurance claim number (HIC), and the nursing home was so badly damaged it has not reopened, how will the hospital obtain the HIC numbers for billing purposes?

A. If the Medicare number or HMO enrollment status of the patient is unknown, we suggest that the hospital contact its intermediary if they cannot obtain it from the prior medical facility or the patient's family members. (9/1/2005)

Billing and Payment: Coordination of Hospital and Dialysis Providers

Q.15. In some cases, an ESRD facility may be able to coordinate with a hospital to dialyze some ESRD patients utilizing inpatient equipment, although the patients were never admitted to the hospital. Once the ESRD facility reopens, can it bill for those services as though they were rendered in the facility, and work out an arrangement with the hospital?

A. Yes, you may bill for the dialysis services rendered in the hospital and reimburse them accordingly. Please document in your records the rationale for the change in location of the services. If you do not bill for the services rendered in the hospital, it is important that the claims billed by both the hospital and your facility do not have overlapping dates of services. (9/1/2005)

Billing and Payment: Bad Debt

Q.16. If providers choose to waive Medicare deductible or coinsurance amounts for victims of the hurricane, may the providers claim these waived amounts on the cost report as bad debt? If so, what documentation will be required in order to satisfy auditors?

A. Providers can waive the coinsurance and deductible amounts and claim bad debt for Medicare patients that they determine to be indigent. The indigence determination must be made on a case by case basis. Documentation requirements stated in Provider Reimbursement Manual I, Chapter 3, Section 312(C) allow that the "provider should take into account any extenuating circumstances that would affect the determination of the patient's indigence". When loss of documentation issues arise in the aftermath of Hurricane Katrina, providers can note their observations or whatever documentation they can with a brief signed statement by medical personnel (e.g., evidence the person is residing in a shelter, Medicaid card, etc.). (9/6/05)

Billing and Payment: Authorization for Emergency Services for HMO Enrollees

Q.17. Will hospitals have trouble obtaining payment from HMOs for their enrollees who were admitted as a result of the disaster without HMO authorization?

A. The HMOs are required by law to pay claims for emergency services inside the service areas without pre-authorization by the HMO. Hospital bills for Medicare HMO enrollees should show that treatment was rendered without pre-authorization because of the disaster. (9/1/2005)

Billing and Payment: Payment Floor

Q.18. Can the 14-day payment floor be temporarily suspended to improve the cash flow of Part A providers and Part B providers?

A. Cash flow problems can better be resolved through accelerated (Part A providers) or advance (Part B providers) payments rather than through suspension of the mandatory payment floor. Intermediaries have been asked to process immediately any requests for accelerated payments or increases in PIP for providers affected by the hurricane. The intermediaries are also authorized to increase the rate of the accelerated payment to 100 percent and extend the repayment period to 180 days on a case-by-case basis. (9/1/2005)

Billing and Payment: Ambulance Services

Q.19. How will ambulance services be paid when patients are moved from hospital to hospital or other locations?

A. Charges for ambulance transportation will be paid according to the usual Payment guidelines. Ambulance transportation charges for patients who were evacuated from and returned to originating hospitals should be included on the inpatient claims submitted by the originating hospitals. Payment will be included in the DRG Payment amounts made to hospitals paid under the prospective payment system. Outpatient claims may be submitted for ambulance charges incurred by those patients who were transported from the originating hospitals and subsequently discharged by receiving hospitals. (9/1/2005)

Q.20. Will Medicare pay for ambulance services during emergency and evacuation situations?

A. The Medicare contractors may make payment for ambulance transportations that evacuated patients from affected locations. The

regulatory requirements must be met (i.e. the vehicle must be an ambulance, the crew must be certified, the patient must need an ambulance transport and the transport must be to an eligible destination). (9/1/2005)

Q.21. Will Medicare consider such ambulance trips under the consolidated billing requirements for skilled nursing facilities?

A. No, such trips will not be subject to consolidated billing. (9/1/2005)

Billing and Payment: Oxygen Equipment

Q.22. If a beneficiary living at home and using a stationary oxygen unit has to be transported to another location, can we pay for any portable oxygen necessary to transport the beneficiary?

A. Yes, payment under Part B can be made. (9/1/2005)

Q.23. If electrical power is lost at the home of a beneficiary using stationary oxygen, can portable oxygen be covered?

A. Yes, the temporary use of portable oxygen can be covered. (9/1/2005)

Attestation

Q.24. What if the attending physician cannot be located? How long must a hospital attempt to contact that physician, and who should sign the attestation?

A. If the attending physician cannot be located, the attestation may be signed by a responsible physician at the hospital, e.g., chief of medical staff or department head. If the hospital is unable to obtain a physician signature, it should document the patient's medical record to show why it was unable to do so. (9/1/2005)

Home Health Agencies

Q.25. How will payments be processed for home health agencies (HHAs)?

A. CMS will advise the FI to facilitate payment for home health services for beneficiaries who have been displaced. The FI will work with the HHAs that have transferred or received patients to ensure that claims are processed timely and issues are addressed quickly. (9/1/2005)

Durable Medical Equipment

Q.26. Does CMS provide any payments for durable medical equipment damaged during a disruptive event?

A. DME will be repaired or replaced if the DME was damaged in the hurricane. (9/1/2005)

Q.27. How can people with Medicare who have been displaced, without access to their usual suppliers get access to durable medical equipment, prosthetics, orthotics and supplies (DMEPOS) such as wheelchairs and therapeutic shoes?

A. Beneficiaries who have access to a telephone may contact 1-800-Medicare for information regarding suppliers serving their current location. Alternatively, if beneficiaries have access to the Internet, they go to the following medicare.gov website to obtain a directory listing suppliers by geography, proximity and name: http://www.medicare.gov/supplier/home.asp

We are aware that suppliers are currently seeking out and serving beneficiaries displaced by Hurricane Katrina who do not have any means of transportation or communication and are in need of DMEPOS items. "Door to door" solicitation of business by DMEPOS suppliers is normally discouraged; however, in light of the current crisis, we encourage suppliers to continue aiding beneficiaries in these situations. (9/9/05)

Physicians

Q.28. Will claims be processed for physicians who were called upon to staff facilities and treat patients outside the normal settings (i.e., shelters)?

A. Yes. The carrier will facilitate these claims to ensure that the provider's questions are answered and the claims processed without interruption. (9/1/2005)

Requirements for Electronic Claims

Q.29. What does CMS recommend for filing claims during a disruptive event?

A. Providers affected by the disaster will be allowed to file paper claims if necessary. (9/1/2005)

Laboratories: Billing and Payment

Q.30. In situations where laboratory specimens are destroyed or compromised by a disruptive event, how will laboratories be paid?

A. Contractors may consider payment for another drawing fee, specimen transport or test if the results have not been communicated to the patient's physician. (9/1/2005)

Provider Enrollment Considerations (Part B)

Q.31. What special consideration is given to physicians and other health care providers who have experienced severe destruction to their facilities?

A. It is possible that some provider locations may have been destroyed or are otherwise uninhabitable. As a result, physicians or other health care providers may set up a practice in a different physical location. Under normal circumstances, the provider would be required to complete an 855-enrollment package. The carrier will streamline the process. Carriers will require at least a fax in order to make a change to a location. The fax must list the provider's Tax I.D. and enough information for the staff to be certain of the provider's identity, but will not require an 855 form. The request will receive priority processing. This process will work if there is an original signature on an original application in-house. Carriers will make recommendations to the RO in situations when there is not an original signature to compare to the fax. (9/1/2005)

Cost Reports

Q.32. Can a provider affected by this disaster receive an extension to the filing of its cost report?

A. Yes, an affected provider may receive an extension to a cost report filing deadline as provided under 42 CFR 413.24 (f) (2) (ii). The request must be reasonable as determined by the specific circumstances substantiated by the provider. Provide copies of both denials and approvals to the RO. (9/1/2005)

Q.33. If a provider affected by this disaster has facility damage or destruction which results in the loss of documentation used to support Payment, what flexibility is available?

A. The FI can accept other data they determine is adequate to substantiate payment to the provider when a facility's records are destroyed. The determination should be on a case-by-case basis. (9/1/2005)

Inpatient Rehabilitation Facilities

Q.34. The disruption to the hospital system caused by the hurricane and its aftermath may require some hospitals to use any available bed to care for patients that have been transferred from the affected areas, or to treat the large number of people requiring hospital care. Will CMS enforce the 75 percent rule for inpatient rehabilitation facilities that admit patients outside of the 13 conditions in order to meet the demands of this crisis?

A. CMS will recognize that some facilities may take a higher number of admissions outside of the 13 conditions to meet the demands of this crisis. Facilities should clearly indicate in the medical record where an admission is made to meet the demands of the crisis. These cases will not be counted toward compliance with the 75 percent rule. (9/1/2005)

Critical Access Hospitals

Q.35. Critical access hospitals (CAHs) are normally limited to 25 beds and to a length of stay of not more than 96 hours, but may need to press additional beds into service or extend lengths of stay to respond to the crisis. Will CMS enforce these limits?

A. CMS will not count any bed use that exceeds the 25-bed or 96-hour average length of stay limits if this result is clearly identified as relating to the hurricane. CAHs must clearly indicate in the medical record where an admission is made or length of stay extended to meet the demands of the crisis. (9/1/2005)

EMTALA Requirements

Q.36. Are hospitals required to comply with all of the requirements of EMTALA during the period of the public health emergency declaration?

A: Generally, yes. However, CMS will not impose sanctions on a hospital located within the jurisdiction of the public health emergency declaration if the hospital redirects or relocates an individual to another location to receive a medical screening examination pursuant to a state emergency preparedness plan or transfers an individual who has not been stabilized if

the transfer is necessitated by the circumstances of the declared emergency within a limited period of time after implementation of the hospital's disaster protocol. This waiver, however, is not effective with respect to any action taken that discriminates among individuals on the basis of their source of payment or their ability to pay. (9/1/2005)

Q.37. Many evacuees from Louisiana, Mississippi, Alabama and Florida are coming to hospital emergency departments merely to obtain refills of prescriptions that they lost when they evacuated from the affected Gulf States. Must these individuals be given a full EMTALA medical screening examination when they come to the emergency department?

A: No, in general, a full medical screening examination for such a patient is not required. CMS' EMTALA regulations make it clear that individuals seeking only prescription refills need not be given a complete medical screening examination, but rather, one that is appropriate for the request that they make. Hospitals may wish to develop specific protocols that include a streamlined screening examination for patients seeking prescription refills, consistent with the regulation cited above. (9/7/2005)

Teaching Hospitals

Q.38. If a teaching hospital affected by the disaster closes even temporarily and therefore residents temporarily train at another teaching hospital will those residents affect the latter hospital's FTE cap on residents for purposes for calculating direct and indirect GME payments?

A. Any hospitals training residents that temporarily train at the teaching hospital because of the disaster will not be affected by the hospital's FTE cap on residents for purposes for direct and indirect GME payment. GME payments will be made to the hospital in which the residents are training. The hospital in which the residents are training must document that the resident is training there because they are unable to train at their original teaching hospital because of the disaster.
(9/6/05)

SNF Billing - 3-day qualifying stay for Medicare Part A SNF benefits:

Q.39. Can Medicare Part A SNF benefits be provided in the absence of a 3-day prior hospital qualifying stay for people who are being evacuated or transferred as a result of hurricane Katrina.

A. Yes. We understand that it may often be difficult to determine whether the 3-day stay requirement has been met. This policy applies to any Medicare beneficiary--

* evacuated from a nursing home in the emergency area,
* discharged from a hospital (in the emergency or receiving locations) in order to provide care to more seriously ill patients
* who needs SNF care as a result of the emergency, regardless of whether that individual was in a hospital or nursing home prior to the hurricane.

Providers must document in medical record both the medical need for the SNF admission and how the admission was related to the crisis created by Hurricane Katrina and its aftermath. Billing instructions will be issued at a later date. (9/7/05)

Q.40. Beneficiaries are presenting to medical facilities for treatment and the facility has no prior knowledge of the individual's medical history or knowledge of drugs used in treatments such as chemotherapy or pain management via infusion. To what extent can Medicare contractors provide medical information and claims history related to the individual in question?

A. Calls of a medical nature should be routed through the Contractor Medical Director (see below) to ensure controlled access to information; discussions should take place clinician to clinician. The Medical Director or designated medical review staff will review the contractor's on-line claims history: 1. to verify a billed diagnosis (i.e., breast cancer), 2: to determine ongoing therapy, such as chemotherapy or chronic pain pump medication, and if so, what drug has been billed on the individual's behalf, billed amount and frequency. If necessary, the Medical Director or designated medical review staff will review CWF history to augment the information in the contractor's claims processing system.

See Question 41 below for the instructions on identifying and authenticating the beneficiary.

Medical Directors:

Alabama Part A - Cahaba GBA: Dr. Greg McKinney (205) 220-1214
Alabama Part B - Blue Cross and Blue Shield of Alabama: Dr. Fred Robertson (205) 220-1216
DMERC - Dr. Stacey Brennan 803-763-5706

Louisiana Part A - TriSpan Health Services: Dr. Barry Whites (601) 352-5864
Louisiana Part B - Arkansas Blue Cross and Blue Shield: Dr. Sidney Hayes
(501) 918-7423; Dr. Lynn Hickman (501) 918-7423
DMERC - Dr. Stacey Brennan 803-763-5706

Mississippi Part A - TriSpan Health Services: Dr. Barry Whites (601) 352-5864
Mississippi Part B - Cahaba GBA: Dr. James Strong (601) 977-5744
DMERC - Dr. Stacey Brennan 803-763-5706

Q.41. Is it necessary for the Medical Director or designated medical review staff to obtain a beneficiary's authorization prior to releasing medical information?

A. No, federal privacy requirements allow for the sharing of information among providers and health plans for purposes of treatment and to avert a serious threat to health and safety. Medicare contractors (the Medical Director or designated medical review staff) should make every effort to obtain the beneficiary's full name, date of birth, health insurance claim number and one additional piece of information such as SSN, address, phone number, effective date(s), whether he/she has Part A and/or Part B coverage, etc. in order to identify and authenticate the beneficiary. In situations where the beneficiary is unable to provide four pieces of identifying information, the Medical Director or designated medical review staff should use their professional judgment to obtain sufficient information necessary to identify and authenticate the beneficiary.

If there is any question as to the validity of the caller, contractors should refrain from providing the information and obtain a call-back number for verification.